U.S. Department of Labor

Office of Administrative Law Judges
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In the Matter of

MANUEL J. MARTINEZ
Claimant

v.

BRADFORD MARINE, INC.
Employer

and

ZENITH INSURANCE COMPANY
Insurer

Date Issued: May 31, 2001

Case No.: 1999-LHC-221

OWCP No.: 06-170315

APPEARANCES

Mr. Barry A. Pemsler, Attorney
For the Claimant

Mr. Ben H. Cristal, Attorney
Mr. Warren K. Sponsler, Attorney
For the Employer

BEFORE:

Richard T. Stansell-Gamm
Administrative Law Judge

DECISION AND ORDER

This case involves a claim filed by Mr. Manuel Martinez for benefits under the Longshore and Harbor Workers' Compensation Act, 33 U.S.C. §§ 901 - 950, as amended ("the Act"). The claim relates to injuries Mr. Martinez suffered when he fell from a scaffolding on June 9, 1996.

The District Director forwarded this case for a hearing to the Office of Administrative Law Judges on September 23, 1998. On January 25, 1999, Administrative Law Judge Ralph A. Romano set a hearing

date of March 30, 1999. However, on March 29, 1999, Judge Romano canceled the proceeding for administrative reasons. In June 1999, Administrative Law Judge David DiNardi rescheduled the hearing for the first week in October 1999. But, based on the parties' stated intentions to settle the case, he did not conduct the hearing. On November 29, 1999, Mr. Pemsler requested another hearing date. Pursuant to a Notice of Hearing, dated February 12, 2000, I conducted the hearing on May 12, 2000 in Fort Lauderdale, Florida. Mr. Martinez, Mr. Pemsler and Mr. Cristal attended the hearing. My decision in this case is based on the testimony presented at the hearing and all the documents admitted into evidence: CX 1 to CX 6 and EX 1 to EX 7.[1]

ISSUES[2]

1. Whether the work-related accident on June 9, 1996 caused Mr. Martinez psychological and psychiatric harm.

2. Whether Mr. Martinez has suffered a disability and its extent.

3. Whether the nature of Mr. Martinez's disability is temporary or permanent.

4. Whether attendant care is necessary and reasonable.

Parties Positions on Remand

Claimant

Due to his fall from the Employer's scaffolding, Mr. Martinez suffered physical injuries including an organic trauma to his head. As a result of his accident, Mr. Martinez continues to suffer psychiatric

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[1]CX - Claimant exhibit; EX - Employer exhibit; ALJ - Administrative Law Judge exhibit; and TR - Transcript.

At the hearing, Mr. Pemsler queried whether I would permit a rebuttal brief. At that time, I indicated counsel could later ask for permission and I would then decide the question. Post hearing, both attorneys filed closing briefs, but Mr. Pemsler also sent an additional brief in rebuttal to Mr. Sponsler's brief. Consequently, Mr. Cristal objected to the rebuttal brief because Mr. Pemsler hadn't asked for permission. In response, Mr. Pemsler indicated that implicit in the submission of the rebuttal brief was a request for its acceptance. I understand the advocacy and fairness motives that drive both counsel and note that I bear partial responsibility for this issue. However, I find it unnecessary to directly address either the objection or the reply because my decision in this case is not predicated on either the timing or substance of any counsel's brief. I simply note that I read all the submissions and found them informative.

[2]At the hearing, Mr. Pemsler also raised an issue concerning the payment of medical bills from the Columbia Behavioral Health Center (TR, page 7). Post-hearing, on July 13, 2000, the parties stipulated that the Employer had paid the identified medical bill. Consequently, that issue has been resolved.

problems. Part of his treatment for this on-going condition involves attendant care.

Employer

Mr. Martinez has recovered from the physical injuries that he sustained in his fall from the scaffolding. He has reached maximum medical improvement concerning those injuries. Since there is no casual connection between his accident and present psychiatric problems, Mr. Martinez is not entitled to continuing disability compensation or treatment, including attendant care.

SUMMARY OF EVIDENCE

While I have read and considered all the evidence presented, I will only summarize below the information potentially relevant in addressing the issues.

For the Claimant - Sworn Testimony

MR. MANUEL J. MARTINEZ[3]
(TR, pages 25 to 47)

[Direct Examination] Mr. Martinez, who is 36 years old, has a high school degree and studied some veterinary science. Prior to June 1996, he was very active at work, enjoyed exercise, swam and played basketball. On the day of the accident, Mr. Martinez was working near the top of boat, standing on a scaffold used to sand and clean the boat. He doesn't remember exactly what happened, but he fell and hit his head and arm. Mr. Martinez was taken to a doctor and loss conscienceness twice.

Dr. Gran treated him for several months. When Mr. Martinez returned to work in light duty, he worked too slowly and would fall asleep. He was bothered by his slow performance. Mr. Martinez became afraid of people because a lot of them are dangerous.

Prior to the accident, he never had any psychiatric treatment or medication. Dr. Gran and Dr. Corin eventually recommended that he see a psychiatrist. The insurer approved his treatment by Dr. Patino. Dr. Patino pulled Mr. Martinez off work and he went to the Columbia hospital based on the doctor's recommendation. Mr. Martinez was in bad shape; he was suicidal, had crying spells and lost weight. Up to that time, he had lived alone in an apartment.

[3]Mr. Martinez was under medication and seemed at times to struggle with paying attention to the questioning. However, I believe he eventually understood the questions and provided full answers.

After his hospitalization, Mr. Martinez lived with his family because he can not live alone. He still had problems with sleepiness and caused trouble with his brothers. About this time, he started to see spirits.

Mr. Martinez received disability compensation through 1997, but the payments stopped. He is receiving disability benefits from Social Security. In June 1998, he had another crisis and, based on Dr. Patino's recommendation, was hospitalized again. He was hearing voices and suicidal. Mr. Martinez has never been married and has no children. The hospital records may say otherwise but the voices told him that he was married.

Mr. Martinez sees Dr. Patino monthly and is taking medication. He can't drive anymore because he gets lost and sees flying cars. His family helps him with his food, hygiene and makes sure he takes his medicine.

Mr. Martinez has flown to Nicaragua twice. His family takes him to the airport and a friend helps him upon arrival.

[Cross Examination] Mr. Martinez's memory has become worse. He experiences dizziness and hears voices. Mr. Martinez states he was perfectly normal before the accident and didn't hear voices. There can be several voices, mostly women, both inside and outside his head. The spirits look like people except they have horrible faces.

His favorite job was book seller. Mr. Martinez had to give up that job because he moved to Miami and also needed a new car.

Mr. Martinez doesn't go to movies anymore because he becomes too sad. His three credit cards pay for his food and clothes. His Social Security Administration payments go towards a house mortgage.

He has family in Nicaragua.

[ReDirect Examination] Mr. Martinez feels bad and incapable of returning to work. Even responding to questions makes him tense, nervous, and dizzy.

MS. FRANCES MARTINEZ[4]
(TR, pages 49 to 67)

[4]Ms. Martinez testified through a sworn Spanish interpreter.

Ms. Frances Martinez is Mr. Manuel Martinez's older sister. She works as a senior clerk for the U.S. Department of Agriculture. Her brother is a completely different person since the accident. Before his injury, Manuel was a dynamic person who led an athletic life. He attended church and was very sociable. Living alone, he had many friends. He never received, nor needed, psychiatric care.

After the accident, he slowed down. You have to repeat things to him before he understands. Since he became ill, Ms. Martinez has taken care of him. She cooks his meals and takes them to him before work. Ms. Martinez returns after her 9 to 5 job to provide additional meals and support. She also washes his clothes and makes sure he takes his medication. Concerning his hygiene, Mr. Martinez gets dizzy and doesn't like to take baths. He sleeps many hours during the day and watches TV. Sometimes he argues with the voices he hears. Ms. Martinez has missed a lot of work caring for her brother. Usually, she spends up to two hours in the morning and several hours after work taking care of him.

She worries about her brother when he's out in public because people don't understand his condition and he can become argumentative and aggressive. Occasionally, he'll have a crisis when he's irritated and he'll start to scream. He hears voices and talks about his sisters' bad spirits. At times he can become violent. Mr. Martinez has assaulted his sister at least once. He said a voice told him to do it.

On his trips to Nicaragua, the family closely coordinates his movements.

[Cross Examination] In the morning, Mr. Martinez will get up and eat his breakfast because he needs to take food with his medication. Then, he may go back to sleep.

She has also returned to visit family in Nicaragua a couple of times in the last 12 years. Since she doesn't know when her brother will hear voices, he could have an episode on a flight.

She doesn't believe her brother is competent to handle his own finances and thinks he's potentially dangerous. Yet, no one has been appointed his guardian. She has never called the police.

For the Claimant - Documentary Evidence

MEDICAL RECORDS - COLUMBIA BEHAVIORAL HEALTH CARE
(CX 1)

According to Dr. Jorge Casariego, who is board certified in psychiatry, on February 26, 1997, Mr. Martinez was admitted as an inpatient at Columbia Behavioral Health Care, based on a referral by Dr. Patino for major depression. Up to that time, Mr. Martinez had struggled with increasingly severe depression with psychotic features that had not responded to outpatient therapy. Dr. Patino's recent treatment had not been able to control Mr. Martinez's deterioration, complaints of headaches, and his

withdrawal. On admission, Mr. Martinez stated he was confused and had a head injury eight months earlier. He was autistic and withdrawn and his affect was "flat, constricted, and frightened." He spoke in a slow, low voice and he seemed to be hallucinating at times. Mr. Martinez expressed delusions that people were out to hurt him. He admitted to auditory hallucinations. His hallucinatory, confused and withdrawn behavior persisted over several days. His treatment consisted of suicide precautions, supportive psychotherapy, psychotic medications, neurological and medical referrals and group therapies. By the time of his discharge on March 10, 1997, Mr. Martinez had gradually responded to the treatment. He was placed in the partial hospitalization program with follow-up care by Dr. Patino. Drug screens taken on February 27, March 13, and 14, 1997 were negative for the presence of illegal drugs or narcotics.

MEDICAL RECORDS - COLUMBIA BEHAVIORAL HEALTH CENTER
(CX 2)[5]

On June 6, 1998, Mr. Martinez, accompanied by his sister, returned to Columbia for additional inpatient treatment due to severe depression and anxiety psychosis. Dr. Casariego again evaluated him. Mr. Martinez showed psychomotor retardation, a lack of appetite and disorganized thought. He was angry with his psychiatrist and easily irritable and frustrated. He was having frequent arguments with his family members. The three reasons listed for hospitalization was danger to himself, inability to care for himself, and outpatient therapy failure. In his psychological profile, his abilities to engage in work, fulfill responsibilities, and problem-solve were evaluated as "impoverished." His behavioral characteristics included non-compliance with medication schedule, guarded suspicions, impaired decision making, impaired judgment and insight, and difficulty functioning. He suffered from loss of sleep and appetite; felt hopeless; responded to internal stimuli; and had slow speech. His sister reported that her brother had refused meals for about a week, no longer took care of himself, had mood swings, and occasionally became aggressive. In fact, the onset for his re-hospitalization was his violence toward his sister. Mr. Martinez indicated that he had a work place accident two years earlier. At present, he heard voices, but refused to identify them. The planned treatment involved medication management, stabilization of mood, and improvement of coping skills. The prognosis for Mr. Martinez was "guarded." The other assessment for his malady was psychotic disorder.

Mr. Martinez was discharged to home on June 16,1998. Towards the end of his stay, Mr. Martinez began to feel less depressed and anxious. He was able to focus in group therapy sessions. During these sessions, he indicated that the voices told him not to trust anyone.

DEPOSITION AND TREATMENT NOTES OF DR. EDGAR PATINO
(CX 3 and EX 6)

In his March 3, 1999 deposition, Dr. Patino, who is board certified in adult psychology and

[5]This exhibit contained numerous duplicate pages.

psychoanalysis, described his treatment of Mr. Manuel Martinez. He first saw Mr. Martinez in January 1997 based on a referral from a neurologist to evaluate his headaches, dizziness, blurred vision and buzzing in his ears. Mr. Martinez and his sister reported that in June 1996, he fell 15 feet from a scaffolding and injured his wrist and head. On the day of the accident he lost consciousness twice. Prior to the incident, Mr. Martinez was a hard working individual. Since his fall, he had become depressed and lethargic.

Upon evaluation, Mr. Martinez was tired and depressed. His speech and walk were slow. Dr. Patino diagnosed post-traumatic stress disorder and a cerebral concussion. He recommended a neuropsychological evaluation to rule out brain damage. At that point, Dr. Patino did not consider Mr. Martinez employable.

Mr. Martinez returned the next month after his supervisor called Dr. Patino concerned that something was wrong. At work, Mr. Martinez was depressed, anxiety-ridden and perspiring. During the visit, Mr. Martinez was very restless. He reported that his January 1997 MRI had been normal. Mr. Martinez was suspicious of his co-workers because they appeared to be against him. He complained of being restless. He suffered headaches and dizziness. He hears voices and talks to a person that looks like a ghost. Dr. Patino concluded Mr. Martinez was "pretty lost" and prescribed antipsychotic and antidepression medication. He felt Mr. Martinez was becoming psychotic.

Two weeks later, Mr. Martinez returned and reported being less depressed. However, he still heard voices and they threatened him. His sister reported the family's concern about Mr. Martinez's withdrawal, mood swings, and sudden aggression. Dr. Patino recommended hospitalization at Columbia. At the hospital, Mr. Martinez received some additional medication to help reduce the voices. He also underwent a neuropsychological evaluation which disclosed post-traumatic stress disorder, post-concussion brain syndrome, and organic affective disorder. That test is consistent with Dr. Patino's diagnosis. In the absence of any prior pathology, Dr. Patino relates those problems to the work-place accident. In other words, the major causative event for his psychological pathology was his fall.

Dr. Patino treated Mr. Martinez about every other month for the next two years; the last visit was January 28, 1999. Despite changes in medication protocols, Mr. Martinez's condition has remained stationary. On occasions, he gets so depressed and hopeless that he stops taking his medication. "Then, he gets worse and his family has to intervene." At times, during his visits with Dr. Patino, Mr. Martinez seems a little better and more communicative. But, on other visits, Mr. Martinez is "almost entirely silent, with poor hygiene, neglecting himself, in pretty poor shape." Dr. Patino believes the therapist helping Mr. Martinez shares his opinion about Mr. Martinez's progress. The therapist describes episodes of audio and visual hallucinations, suicidal ideations, intense depression, and mild improvements. Over this course of two years, Mr. Martinez has been unemployable. Since there has been no change for the last two years, Dr. Patino does not see much hope for future improvement in Mr. Martinez's condition. Consequently, Mr. Martinez has reached maximum medical improvement. He is severely impaired due to his psychiatric condition. Due his forgetfulness or willful neglect, Mr. Martinez needs supervision to ensure he continues to take his medication. Also, in periods of deep depression, he needs help with his basic living needs and

hygiene. If upon admission to a hospital, Dr. Casariego assessed Mr. Martinez's global assessment of functioning ("GAF") as between 10 and 20, then hospitalization was warranted since that's a very low GAF rating. Normally functioning adults rate between 80 and 100. A GAF below 50 may indicate hospitalization is warranted.

Dr. Patino has reviewed Dr. Diaz's medical report and his opinion that Mr. Martinez's condition can not be linked to his work-place accident. They have a difference of opinion. But, Dr. Patino noted that Dr. Diaz also diagnosed post-concussional syndrome. Dr. Patino agreed with a medical journal article that patients with mild traumatic brain injury can exhibit persistent emotional, cognitive, and behavioral symptoms, which may produce functional disability. Mr. Martinez exhibits such symptoms. Dr. Patino pointed out that Mr. Martinez suffered a closed head injury which "is a real mystery" in regards to brain injury, even though an MRI or CT scan may produce normal results. In other words, the brain cells may be damaged without hemorrhage.

Dr. Patino opined Mr. Martinez will need psychiatric care "for years." Dr. Patino may have told Mr. Martinez not to work for a period of time, about February 1997. He doesn't need 24 hour a day supervision for his medication. In March 1998, Dr. Patino indicated to counsel for the Employer that one hour a day of supervision might be sufficient. But, at the deposition, Dr. Patino pointed out that due to Mr. Martinez's overall condition, he may need more supervision. Dr. Patino is aware that Mr. Martinez is a licensed driver and drives sometimes to the consultations. Dr. Patino has imposed no driving restrictions. He is also aware that Mr. Martinez has traveled to Nicaragua. At the same time, Dr. Patino notes that Mr. Martinez may have been hospitalized in Nicaragua during one of the trips. When Mr. Martinez takes his medication regularly, he has less flare-ups and is generally more stable. But, he's still not capable of work because his level of functioning is "pretty low." He's "pretty fragile. . .[and] very brittle." If he attempted work, Mr. Martinez would probably experience a flare-up.

On the causation issue, Dr. Patino again explained that there may be more internal brain damage from an accident than is detectable by an MRI or CT scan. The best way to establish a link is through a neuropsychological evaluation, which Dr. Patino had ordered.

In a letter response to inquiries from Employer's counsel, Dr. Patino observed that Dr. Diaz believed Mr. Martinez did not suffer loss of consciousness, which is contrary to Dr. Corin's observations that he did lose consciousness. Similar to Dr. Patino, Dr. Diaz also recorded the absence of any prior history of psychological problems.

In an indorsement to a March 16, 1998 letter from Employer's counsel, Dr. Patino concurred that Mr. Martinez needed attendant care of about 10 minutes a day to ensure Mr. Martinez took his medication and two to three 15 minutes sessions during his waking hours to check on his status.

Dr. Patino's treatment notes record about 18 visits with Mr. Martinez between January 29, 1997

through July 1998. The attached records also include x-rays taken one hour after his fall striking his back and head. The wrist x-rays show a fractured wrist. The spinal x-ray was normal. Dr. Seley treated Mr. Martinez's wrist fracture with a splint, prescribed rest, and restricted him to light work only.

A Spanish medical summary records Mr. Martinez's treatment in a Nicaraguan hospital in September 1997 for convulsions and confusion.

DEPOSITION OF DR. JORGE I. CASARIEGO
(CX 4)

In his March 4, 1999 deposition, Dr. Casariego, a board certified psychiatrist, discussed Mr. Martinez's hospitalizations. Dr. Casariego first examined Mr. Martinez on his referral to Columbia from Dr. Patino for hospitalization in February 1997. At that time, he was autistic and withdrawn. He appeared to be hallucinating and had psychomotor slowing. The diagnosis was major depression with psychosis. The hospital took suicide precautions, administered psychotic medication, and provided psychiatric therapy. Dr. Casariego considered Mr. Martinez severely disturbed and gave him a GAF assessment of between 10 and 20 upon admission, "the low end of the spectrum" and 40 at discharge on March 10, 1997.

Mr. Martinez again came under Dr. Casariego's care in June 1998 with a readmission to the hospital. He presented with similar symptoms and the same diagnosis. Mr. Martinez had become violent towards his sister and he complained about hearing voices and feeling very depressed. Dr. Casariego stated that this June 1998 re-admission is significant because it shows that Mr. Martinez is a very disturbed individual and his condition had not improved over the course of a year. His problem is chronic and very severe.

Dr. Casariego evaluated in depth the March 1997 neuropsychological test results. He pointed out that some of Mr. Martinez's scores suggested a moderate impairment to his auditory processes and temporary disruption of global intellectual functions most likely associated with a post-concussion brain syndrome and/or an emotional disorder related to a traumatic experience. The test suggests an ongoing pathology in the right hemisphere that is the likely the result of an accident. In addition, the test indicates a visual motor deficit that may be associated with a cerebral lesion. In summary, the test adds to Dr. Casariego's suspicion that Mr. Martinez had a concussion type of syndrome. In particular, the significant drop in intellectual cognitive capacity points to a significant problem.

When presented with the assumptions that prior to the accident Mr. Martinez was a normally functioning adult, he fell 10 to 15 feet off a ladder, struck the left side of his body and head, lost consciousness, returned to work but suffered increasing cognitive and psychological problems, had normal MRI and CT scan test results, Dr. Casariego opined that Mr. Martinez's psychological/psychiatric and cognitive problems arose as a result of the accident. He had seen no evidence to support any other

explanation.

In terms of care, Dr. Casariego believed Mr. Martinez needed further active support. He apparently tried living alone but had problems with his medication and feelings of loneliness. Dr. Casariego's prognosis for him is guarded. And, based on the severity and probable chronicity of his problems, Mr. Martinez is handicapped.

Psychosis is not a typical symptom of a post traumatic stress disorder. The disorder can produce depression. Psychosocial family stressors can also contribute to depression. Psychosis can develop from severe depression, even in the absence of an organic brain injury. Dr. Casariego has not treated many people with a psychosis that developed due to a brain injury. It is a rare occurrence for Dr. Casariego, but at the same time, he does not see many brain injury patients in his practice. Such a psychosis would probably develop within a year of the injury. Medication can do a great deal to control psychotic symptoms. And, failure to take such medication could lead to an increase in such psychotic symptoms such as hearing voices.

In Dr. Casariego's opinion, post-concussion syndrome typically does not have "positive findings on scans . . . the changes are usually independent of major damage shown on those imaging procedures."

DEPOSITION OF DR. JOSE J. DERGAN
(CX 5)

In a March 9, 1999 deposition, Dr. Dergan, a clinical psychologist, discussed his evaluation of Mr. Martinez. On March 7, 1997, Dr. Dergan conducted a neuropsychological assessment of Mr. Martinez. He generally tested his cognitive capabilities. Due to the inconsistencies during an intelligence test and the number of distortions and omissions in another exam, Dr. Dergan believed there was evidence of both an ongoing pathology in the right hemisphere and a concussion. Mr. Martinez had normal verbal functioning but "very low" non-verbal functioning. These factors, coupled with the circumstances of his accident led Dr. Dergan to conclude that "most of his impairment is reflective of that accident." He noted there was "no evidence of any other neurological impairment prior to the accident." Dr. Dergan's diagnosis was post-concussion brain syndrome with its associated cognitive deficit. He also pointed out that is was not unusual to see a worsening of these symptoms. The absence of abnormal MRIs or CT scans did not alter his opinion because 75% of the patients he has evaluated or treated were diagnosed with post-concussion brain syndrome and did not have abnormal CAT scans.

Emotionally, Mr. Martinez demonstrated a lot of disorganization. He would perceive something and then act differently. For example, although Mr. Martinez will experience self-condemnation and severe depression for his out of control behavior, he is unable to prevent a another out of control event. Mr. Martinez was very depressed and Dr. Dergan relates that situation to an organic effect of his injury.

The severity of Mr. Martinez's post-concussion syndrome is moderate. That is, the cognitive deficit portion of his problems was moderate. His emotional problems could be more severe. Over a course of intensive psycho-therapy and medication, such a condition may improve. Dr. Dergan has treated patients with moderate post-concussion syndrome who have successfully returned to the work force. To determine whether Mr. Martinez's impairment was permanent or improving, Dr. Dergan would have to conduct another test. Mr. Martinez fully cooperated with the tests; he was not malingering. The fact that Mr. Martinez was re-hospitalized a year later for similar emotional issues suggests a chronicity component to his emotional problems.

In the attached neuropsychological test report, Dr. Casariego records that following the 1996 accident, Mr. Martinez lost consciousness for a few minutes. Mr. Martinez also reported that he injured his neck in a car accident in 1993.

MEDICAL EXAMINATION AND REPORT - DR. BERNARD GRAN
(CX 6)

On June 14, 1996, five days after Mr. Martinez fell off the scaffolding, Dr. Gran conducted a neurological evaluation. Mr. Martinez stated he fell 13 feet off a ladder and landed on his left side, body and head. He temporarily lost consciousness at the accident site and then a second time at the hospital. The hospital x-ray and scan of his head did not reveal any problems. He complained about balance problems and a headache on the left side of his head. He also reported a prior motor vehicle accident in 1993 which caused a neck injury, which had been resolved. Upon examination, Dr. Gran found normal motor movements and reflexes. He returned Mr. Martinez to light duty.

For the Employer - Sworn Testimony

MR. JERRY ADATO[6]
(TR, pages 72 to 256)

[Direct Examination] In preparing the labor market survey for this case (EX 7), Mr. Adato reviewed Mr. Martinez's medical records and the opinions of Dr. Corin, Dr. Gran, Dr. Patino, Dr. Diaz, and Dr. Cardella. He also conducted a vocational evaluation. However, as directed, Mr. Adato prepared the labor market survey only in terms of the limitations and restrictions set out by Dr. Diaz, Dr. Gran, and Dr. Corin.

Mr. Martinez has education in biology, chemistry, and anatomy. In addition to being a boat painter, he has worked as a book salesman, home painter, and clerk/cashier. He is self-taught in English and fluent

[6]Absent any objection, I found Mr. Adato to be an expert in the labor market survey field (TR, pages 72 and 73)

in Spanish. With this background, he has notable transferable job skills.

In terms of limited public contact, the jobs of auto parts store driver, security guard, deck hand, shipping assistant, car lot porter, baggage cargo handler, office cleaner, and loader are more suitable. The unemployment rate in Miami is at a 20 year low.

For the Employer - Documentary Evidence

DEPOSITION OF MR. MANUEL J. MARTINEZ
(EX 1)

In his February 23, 1999 deposition (taken about 16 months prior to my May 2000 hearing), Mr. Martinez indicated he presently lived with his brother, sister, niece and mother. Another sister, Francis, recently moved out.

Mr. Martinez was born in Nicaragua. He lived in Cuba for five years and studied veterinary medicine. He came to the United States in 1983. His prior jobs included book seller, auto parts sales clerk and painter. He has operated a cash register and computer. At the time of his accident, Mr. Martinez was a painter's helper at Bradford Marine. He doesn't remember the details of the accident. His first memory is being in the hospital. In his fall, Mr. Martinez also injured his left hand, but it has healed. In a previous motor car accident, he injured his neck. That injury is also healed. He never hit his head before or suffered any head injury before his fall at Bradford Marine.

Mr. Martinez has persistent headaches and periodic blurred vision. He also experiences dizziness. He has trouble due to his headaches and "people getting in my head." The headaches make him tired, upset, and sad. To escape, he rides in his car and feels the breeze. Mr. Martinez is a licensed driver and drives nearly every day.

He visits Dr. Patino about once a month. Sometimes, Mr. Martinez does not take his prescribed medicine and feels worse. "It's like the end of my life." Therapy has been helpful in his effort to avoid the voices in his head.

After his injury, Mr. Martinez tried to go back to work, but he started feeling bad and the co-workers didn't like him. He wants to go back to school to study medicine. On a typical day, Mr. Martinez gets up around 10:00 a.m. His mother is usually home. He showers occasionally when reminded by his family members. His family also helps him with his grocery shopping, medication, and bills. Mr. Martinez receives $500 a month from Social Security.

In considering whether to return to work, Mr. Martinez explained that he has problems relating to

people. He described an altercation in a restaurant with a young woman and her family.

Mr. Martinez has flown a couple of times to Nicaragua to visit family members.

MEDICAL EXAMINATIONS - DR. BERNARD GRAN
(EX 2)

Dr. Gran, board certified in neurology, conducted several neurological follow-up examinations between July 1996 and January 1997. On July 26, 1996, Mr. Martinez returned complaining about increased left neck pain that radiated into his head. At work, the acute pain caused him to lay down a few hours. Upon physical examination, Dr. Gran noted some left sided tenderness and limited muscle flexion. After observing that a spinal x-ray was normal. Dr. Gran suggested the possibility of a left side cervical radiculopathy. Dr. Gran continued him on light duty.

On August 6, 1996, despite Mr. Martinez description of an intense headache, Dr. Gran believed he was improving. All the medical tests produced normal results and although Mr. Martinez seemed "slightly unstable," the physical examination was normal. Dr. Gran's impression was post concussion injury. He suggested Mr. Martinez could return to work in full capacity within three weeks.

On January 17, 1997, Mr. Martinez returned complaining about dizziness, fatigue, and headaches. Dr. Gran's neurological examination was normal. Dr. Gran noted that he had suffered a post concussion injury and still experienced dizziness. But, from a neurological perspective, Dr. Gran had nothing further to offer Mr. Martinez.

Ultimately, Dr. Gran concluded Mr. Martinez could return to work with a maximum medical improvement ("MMI") date of August 26, 1996. He listed his permanent impairment rating as zero.

MEDICAL EXAMINATION - DR. MORTON S. CORIN
(EX 3 and CX 3)

On January 22, 1997, Dr. Corin, a board certified neurologist, evaluated Mr. Martinez based on a referral by Dr. Cardella, who conducted a normal physical examination on January 10, 1997 and could not identify the basis for his complaints of increasing dizziness. Mr. Martinez reported difficulties with headaches and dizziness over the prior seven months. He described his fall from 15 feet and noted that he lost consciousness briefly on the way to the hospital. Dr. Corin observed the hospital x-rays were normal and Dr. Seley, an orthopaedic surgeon, had treated Mr. Martinez for a fractured left wrist. In addition, an EEG by Dr. Gran was apparently normal. Upon examination, Dr. Corin found no neurologic abnormalities. However, Mr. Martinez did cry during the exam, stating he just wanted to feel better. Dr. Corin's diagnosis was post concussion syndrome. He recommended brain imaging and a psychiatric evaluation. Dr. Corin released Mr. Martinez to work with only one restriction about working at heights. Dr. Corin anticipated MMI in two weeks.

Mr. Martinez returned to Dr. Corin on February 5, 1997. Dr. Corin reported that the January 29, 1997 head MRI was normal. His neurological examination disclosed no problems either. At this session, Mr. Martinez reported one episode of paralysis from the waist down. He was not communicative, maintained poor eye contact, and didn't respond to queries about his previously admitted auditory hallucinations. Dr. Corin explained to Mr. Martinez there was no evidence of any significant structural neurologic dysfunction. Dr. Corin released Mr. Martinez to return to work without restriction and opined he had reached MMI without any permanent impairment from a neurological perspective. At the same time, Dr. Corin recommended psychiatric care. His final diagnosis was post head trauma syndrome and somatiform[7] disorder.

MEDICAL OPINION - DR. ANGEL R. DIAZ
(EX 4 and CX 3)

On March 26, 1998, Dr. Diaz, a board certified psychiatrist, conducted a medical record review and examination of Mr. Martinez. Dr. Diaz read the neurologic reports of Dr. Gran and Dr. Corin, the neuropsychological evaluation by Dr. Dergan, and Dr. Patino's treatment notes (though they were difficult to decipher). He also discussed the case directly with Dr. Patino. Dr. Diaz indicated that Mr. Martinez had suffered a 15 foot fall in June 1996, but did not lose consciousness. Mr. Martinez described problems with persistent headaches, concentration, dizziness, and whole body pain. Mr. Martinez was taking psychiatric medication. At times, he had auditory hallucinations and saw shadows. At the completion of his evaluation, Dr. Diaz opined that Mr. Martinez had post concussion syndrome and a GAF rating of 65. He acknowledged that Dr. Patino believed Mr. Martinez had a psychosis, but Dr. Diaz had a different opinion due to the "absence of any organic etiology that could explain Mr. Martinez's psychiatric problems." Dr. Diaz pointed out that the neurological examination, the MRI, the CT scan, and the EEG were all unremarkable. In addition, he would expect to see improvement in the post concussion syndrome with the passage of time rather than a worsening condition. Dr. Diaz added that Mr. Martinez's cognitive impairments were "also difficult to explain based on his accident." In particular, he commented that Mr. Martinez suffered "a head concussion with no loss of consciousness." And, Dr. Diaz found it difficult to understand how Mr. Martinez could endure the rigors of travel to Nicaragua with his stated problems. Ultimately, Dr. Diaz could not establish any causation between the June 1996 accident and Mr. Martinez's psychiatric problems. According to Dr. Diaz, "[t]he only way to explain the psychiatric symptoms before mentioned is by Mr. Martinez having a significant past psychiatric history which he currently denies."

Based on his examination, Dr. Diaz informed the insurer that Mr. Martinez could return to work without restriction. He had reached maximum medical improvement on March 30, 1997 with a 3% psychiatric impairment rating. Dr. Diaz added "for psychiatric symptoms causally related to his 6/9/96 accident, he is in no need of attendant care."

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[7]In psychiatry, the conversion of mental experiences or states into bodily symptoms. DORLAND'S ILLUSTRATED MEDICAL DICTIONARY 1544 (28th ed 1994).

DEPOSITION - DR. ANGEL R. DIAZ
(EX 5)

In a March 3, 1999 deposition, Dr. Diaz stated that in addition to his prior review of Mr. Martinez's medical record, he also saw the Columbia hospitalization records. Next, Dr. Diaz recalled that at his evaluation, Mr. Martinez was focused, able to present a detailed history, and well groomed. He did not appear to be in any pain. At that time, Mr. Martinez's medications included anti-depression and anti-psychotic drugs.

Due to the lack of detail about the voices, Dr. Diaz found Mr. Martinez's complaints of auditory hallucinations to be atypical, which might call into question his credibility. Mr. Martinez denied any psychiatric history predating the accident. He drives a car and is capable of handling himself.

During the visit, Dr. Diaz conducted a mental status examination. Based on his subjective and objective observations, the doctor concluded Mr. Martinez was goal oriented, mildly depressed and anxious. He had a flat affect but exhibited adequate judgment and insight. Mr. Martinez had some psychological factors affecting his personality and the way he handled stress. These stressors were mild. Mr. Martinez's GAF rating was 65. A score of 100 is optimal and a normal adult falls between 85 to 90.

Dr. Diaz discussed the case with Dr. Patino. He agreed with Dr. Patino that Mr. Martinez might be suffering psychosis (which he defines as a person losing contact with reality) but the reason for the problem was not clear. Since there was no objective evidence of brain damage, it was "quite difficult" for Dr. Diaz to understand how Mr. Martinez developed his psychotic symptoms that required hospitalization and anti-psychotic medication. And, since there is no "demonstrable physical findings" from the accident, Dr. Diaz could not link the accident to Mr. Martinez's psychiatric symptoms. His condition is probably related to some other explanation, such as an undisclosed prior psychiatric history. Dr. Diaz is aware of cases involving closed head injuries and psychiatric symptoms. But in those cases, the symptoms usually develop within 72 hours of the trauma and are usually brief, responding well to treatment. But Mr. Martinez's problems have persisted over a year and a half. It is "highly unlikely" for Mr. Martinez to develop psychiatric symptoms five to seven months after his head trauma. Other possible cause of psychotic problems are substance abuse, major depression, personality disorder, and organic injury such as a tumor.

Mr. Martinez's ability to care for himself and participate in international travel is inconsistent with his described psychotic symptoms. According to Dr. Diaz, Mr. Martinez may return to work without restrictions. He can not establish causation between the accident and the psychosis. Mr. Martinez does not need attendant care. He has reached MMI and has a 3% impairment rating for his overall psychiatric condition, which is unrelated to the work-place accident.

Dr. Diaz does not dispute Mr. Martinez's psychotic symptoms. Yet, in terms of etiology, Dr. Diaz does not concede that Mr. Martinez's psychotic symptoms were not voluntary. Instead, he is perplexed and confused in trying to understand how those symptoms could have been caused by the accident.

According to a Nicaragua hospital report, Mr. Martinez was treated in an emergency room for seizures during an October 1997 visit. Mr. Martinez also struggled with unconsciousness and was in a confused state. The physician's impression was post traumatic epilepsy. This evidence shows Mr. Martinez wasn't functioning normally when he arrived in Nicaragua on that trip.

Dr. Diaz disagrees that his opinion is less probative because he only saw Mr. Martinez once. In fact, he believes his examination is more objective. Over time, a treating physician may lose objectivity.

Dr. Diaz is aware of medical experts who have made a diagnosis of psychosis of individual who suffered head trauma but did not present objective evidence of damage. However, in his experience, such psychosis has a quick onset and is brief.

RE-EMPLOYMENT EVALUATION AND LABOR MARKET SURVEY
(EX 7)

On March 22, 1999, Mr. Adato conducted a re-employment evaluation of Mr. Martinez. Noting that he was instructed to rely solely on the limitations imposed by Dr. Gran and Dr. Diaz. Mr. Adato indicated Mr. Martinez had numerous transferable job skills based on his past work experience and education. Other than Dr. Gran's limitation on working at heights, Mr. Martinez had the capability to return to any of his prior occupations.

Mr. Adato also identified dozens of job openings in the local area that did not require Mr. Martinez to work in high locations. The jobs ranged from sales clerk to deck hand to veterinary assistant. The hourly wages ranged from $6 to $15; the median rate was $9. Based on the historic low unemployment rate in the local area, Mr. Adato opined that Mr. Martinez would have no difficulty obtaining employment.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

Stipulations of Fact

At my hearing, the parties stipulated to the following facts: a) At the time of the injury, the average weekly wage was $340; b) On the date of the injury, June 9, 1996, an employer/employee relationship existed between the parties; c) the Employer was advised of the injury in a timely manner; and, d) The Claimant filed a timely claim within the meaning of the Act.

Entitlement To Benefits

To obtain disability compensation under the Act, Mr. Martinez must prove by a preponderance of the evidence that he has suffered a work-related injury that precludes his return to work as a longshoreman or harbor worker and has adversely affected his ability to earn an income.
The first issue in this case relates to the existence of a work-related injury. If such an injury exits, the remaining issues concern its economic (loss of wage earning capacity) and medical (necessary and reasonable medical care) consequences.

Issue No. 1 - Causation

The principal issue in this case is whether Mr. Martinez has suffered a work-related injury. That is, whether his psychosis and related psychological problems were caused by his fall from the Employer's scaffolding on June 9, 1996. In determining whether there is a causal relationship between Mr. Martinez's mental injuries and the accident, I am guided by several adjudication principles and must make several determinations involving the *prima facie* case of entitlement, a presumption under Section 20 (a) of the Act, a shifting burden of production, and an ultimate burden of proof. In making these determinations, I am entitled to assess the credibility of the witnesses, to weigh the evidence and draw inferences from it; and, I am not bound by the opinion or theory of any particular medical expert. *Banks v. Chicago Grain Trimmers Association, Inc.*, 390 U.S. 459 (1968), *reh. denied*, 391 U.S. 929 (1969).

Prima Facie Case

The fundamental initial step in the disability claim process is the establishment of a *prima facie* case of entitlement, which consists of two elements. First, Mr. Martinez, as the Claimant, has the burden of establishing that he sustained a harm or pain. Second, Mr. Martinez must show that an accident occurred in the course of employment, or conditions existed at work, which could have caused the harm or pain. *Kier v. Bethlehem Steel Corp*, 16 BRBS 128 (1984). The establishment of this preliminary *prima facie* case of entitlement is significant because it then invokes a presumption under Section 20 (a) of the Act.

Injury[8]

Concerning the first element, a claimant has sustained an injury when he or she experiences some harm, pain, or something unexpectedly "wrong within the human frame." *Wheatly v. Adler*, 407 F.2d 307, 313 (D.C. Cir 1968)(*en banc*). A psychological impairment can be an injury under the Act. *Director*,

[8]The parties stipulated that the date of the injury was June 9, 1996. However, because Mr. Martinez suffered a fractured wrist in his fall and I did not clarify the nature of the injury in the stipulation, that agreement is insufficient to establish the psychiatric injury.

OWCP v. Potomac Elec. Power Co. (Brannon), 607 F. 2d 1378 (D.C. Cir. 1979); *see also, Turner v. Chesapeake & Potomac Tel. Co.*, 16 BRBS 255 (1984) (depression due to a work-related disability), *and Spence v. ARA Food Serv.*, 13 BRBS 635 (1980) (headaches from a work-related incident are compensable). Even the claimant's credible complaints of subjective symptoms and pain can be sufficient to demonstrate the requisite harm. *Sylvester v. Bethlehem Steel Corp.*, 14 BRBS 234, 236 (1981), *aff'd sub. nom. Sylvester v. Director, OWCP*, 681 F. 2d 359 (5th Cir. 1982). The claimant does have to allege the injury during some stage of the claims proceedings, but not necessarily within the initial report of injury. See *U.S. Industries/Federal Sheet Metal v. Director, OWCP (Riley)*, 455 U.S. 608 (1982), *rev'g Riley v. U.S. Industries/Federal Sheet* Metal, 627 F.2d 455 (D.C. Cir 1980); and, *Dangerfield v. Todd Pacific Shipyards Corp.*, 22 BRBS 104 (1989) (claimant did not allege a low back injury in the initial report of injury, but she subsequently received treatment for the low back injury and sought benefits for the injury).

In Mr. Martinez's case, the objective medical tests, including an MRI and CT scan of his head and brain, have failed to disclose any significant physical damage. Likewise, both neurologists, Dr. Gran and Dr. Corin, have determined that Mr. Martinez has no functional, neurological deficit. However, these tests and opinion do not directly address the issue of Mr. Martinez's psychosis.

Concerning the presence of psychosis, while Dr. Diaz has suspicions about Mr. Martinez's psychiatric symptoms, the other two psychiatrists, Dr. Patino and Dr. Casariego, who treated Mr. Martinez, join the psychologist, Dr. Dergan, who administered the neuropsychological test, in concluding that Mr. Martinez struggles with keeping in touch with reality. As I will discuss later, the opinions of Dr. Patino, Dr. Casariego, and Dr. Dergan have greater probative value than Dr. Diaz's assessment. Their opinions also represent the preponderance of the evidence concerning the presence of a psychological and psychotic injury and outweigh Dr. Diaz's suspicions. They agree that something within the psychiatric realm of Mr. Martinez's human frame is wrong. The combined expert opinions of Dr. Patino, Dr. Casariego, and Dr. Dergan establish that Mr. Martinez has a psychiatric disorder.

Accident

Turning to the second element of the initial *prima facie* showing of entitlement, the preponderance of the evidence establishes that on June 9, 1996, while working as a paint helper at Bradford Marine, Mr. Martinez fell at least 13 feet from a scaffolding and landed on his left wrist, the left side of his body and head. The fall was severe enough to cause a fracture of Mr. Martinez's left wrist and to make him lose consciousness at least once.[9] Since Mr. Martinez struck his head in the fall and did pass out for a while,

[9]Although he apparently told Dr. Diaz otherwise two years after his fall, Mr. Martinez in his earlier contacts with treating physicians stated he had lost consciousness. For example, Dr. Gran recorded a loss of consciousness within five days of the accident. As discussed later in greater detail, I find the preponderance of the evidence

(continued...)

I find the deceleration forces and trauma to Mr. Martinez's head due to the his June 9, 1996 fall could have caused adverse psychotic consequences.

Presumption Under Section 20 (a) of the Act

Under Section 20 (a) of the Act, 33 U.S.C. § 920 (a), it is presumed, in the absence of substantial evidence to the contrary, that the compensation claim comes within the provisions of the Act. The courts have applied this language to the establishment of a nexus between the employee's injury and employment activities. *Swinton v. J. Frank Kelly, Inc.*, 554 F.2d 1075 (D.C. Cir 1976) *cert. denied*, 429 U.S. 820 (1976). However, to invoke the presumption, a claimant must first establish a *prima facie* case. *U.S. Industries/Federal Sheet Metal v. Director, OWCP (Riley)*, 455 U.S. 608 (1982), *rev'g Riley v. U.S. Industries/Federal Sheet* Metal, 627 F.2d 455 (D.C. Cir 1980). Once the claimant establishes a *prima facie* case, a presumption arises under Section 20 (a) that the employee's injury arose out of his or her employment. *Lacy v. Four Corners Pipe Line*, 17 BRBS 139 (1985). If the presumption is invoked and the employer fails to respond, then the claimant is entitled to compensation under the Act for an injury arising out of, and in the course of, employment.

Having proven that he has suffered a mental harm and that he was in an accident at work that could have caused such harm, Mr. Martinez has established a *prima facie* case that invokes the presumption under Section 20 (a) of the Act that his psychosis was caused by his work-related accident.

The Shifting Burden of Production

Once the claimant establishes a *prima facie* case and invokes the Section 20 (a) presumption, the burden of production of evidence shifts to the other party, the employer, to indicate the claimant's condition was not caused or aggravated by the employment. *Brown v. Pacific Dry Dock*, 22 BRBS (1989). To rebut the Section 20 (a) presumption, the employer must present substantial evidence (specific and comprehensive medical information) that would support a finding that a connection between the bodily harm and employment or working conditions is absent or has been severed. *Parsons Corp. v. Director OWCP (Gunter)*, 619 F.2d 38 (9th Cir. 1980); and, *Kier v. Bethlehem Steel Corp*, 16 BRBS 191 (1990) (unequivocal physician testimony that no relationship exists between an injury and a claimant's employment may be sufficient to rebut the presumption). This adjudication stage does not involve a shift in the burden of proof. When there has been a work- related accident followed by an injury, the employer need only introduce medical testimony or other evidence contradicting the existence of a causal relationship and need not necessarily prove some other agency of causation to rebut the Section 20 (a) presumption. *Stevens v. Todd Pacific Shipyards*, 14 BRBS 626 (1982). At the same time, the presumption is not rebutted merely by suggesting an alternate way that the claimant's injury might have occurred. *Williams v. Chevron, U.S.A.*, 12 BRBS 95 (1980). If the employer presents substantial contrary evidence, then

[9](...continued)
establishes that Mr. Martinez did pass out briefly on the day of the accident.

the Section 20 (a) presumption is overcome and all the evidence in the entire record is weighed in the next, and last, adjudication step - determining whether the claimant has met his or her ultimate burden of proof. See *American Grain Trimmers, Inc. V. Director (OWCP) (Janich),* ___F.3d___ (7th Cir., June 21, 1999) (Docket No. 97-3080).

Although Mr. Martinez has invoked the Section 20 (a) presumption of causation, the Employer contends there is no causal relationship between Mr. Martinez's psychosis and his fall from the scaffolding. In other words, Bradford Marine contests the issue of causation and has attempted to rebut the presumption through medical opinion.

Both examining neurologists, Dr. Gran and Dr. Corin, did not find any abnormal neurological problems with Mr. Martinez. From a neurological perspective, nothing is wrong with Mr. Martinez. And, by implication, this absence of neurological damage to Mr. Martinez after his fall seems to preclude any link between the accident and Mr. Martinez's condition. However, I consider their concurring opinions that Mr. Martinez is neurologically normal insufficient evidence for rebuttal because neither doctor directly addressed whether there was a link between the accident and Mr. Martinez's psychosis. Both doctors recognized they were solely addressing the neurological sphere of Mr. Martinez's condition. Neither attempted to evaluate the extent or cause of Mr. Martinez's psychotic symptoms, including his hallucinations. In fact, Dr. Corin recommended a psychiatric evaluation. As a result, their expert opinion on the functionality of Mr. Martinez's neurologic system, standing alone, does not represent sufficient, contrary evidence to overcome the Section 20 (a) presumption concerning the causation of Mr. Martinez's psychosis.

Dr. Diaz, as a psychiatric expert, does directly address the causation issue and is unable to find any connection between Mr. Martinez's fall and his psychosis. Although Dr. Diaz's opinion is generally documented, I consider his opinion to have diminished probative value for several reasons to the extent that it fails to represent the requisite substantial contrary evidence to rebut the statutory presumption of causation.

First, the probative value of Dr. Diaz's medical opinion is adversely affected by the seemingly restrictive evaluation criteria that he used for his analysis. In assessing whether Mr. Martinez suffered mental harm from his fall, Dr. Diaz noted the absence of any evidence of physical brain damage. Because the neurological examinations, brain MRI, and brain CT scan were normal Dr. Diaz could not link Mr. Martinez's fall to his psychosis. Apparently based on his experiences as a psychiatrist, Dr. Diaz requires the presence of physical harm to the brain, or development of a psychosis within 72 hours of an accident, before he will diagnose a psychosis from an accident. Had Dr. Diaz provided a viable explanation for his position, I would have less concern. Yet, when his opinion was challenged by medical studies and opinions that indicated the possibility of psychosis from a closed head injury or mild brain trauma which did not involve observable brain damage and the onset of psychotic symptoms occurred more than 72 hours after the accident, Dr. Diaz refused to seriously consider such a possibility because he hadn't personally seen

any such cases.

Second, and closely related to my first concern with the probative value of his opinion, Dr. Diaz suggests other possible explanations, besides a fall, for Mr. Martinez's psychiatric problems which have no basis within the context of the facts of this case. As noted in the legal discussion, the Employer does not have to prove some other cause for the injury; but Dr. Diaz's propensity to suggest seemingly baseless, alternative explanations for Mr. Martinez's condition adversely affects the ability of his opinion to pass the threshold for substantial contrary evidence. His proposals also illustrate his steadfast unwillingness, due to his singular experience, to included Mr. Martinez's 13 plus foot fall on his head as a possible reason for his psychological problems. Rather than include the June 9, 1996 fall within the range of possible etiologies for Mr. Martinez's psychosis, Dr. Diaz presents several implausible alternative causes.

As one principal, alternate explanation, Dr. Diaz suggests that Mr. Martinez's psychotic problem may be related to an unreported prior psychiatric history. As indirect support, Dr. Diaz noted that Mr. Martinez failed to provide details about the hallucinatory voices which called into question both his hallucination complaints and his credibility. Upon my review of the entire record, including the hospital and therapeutic session notes by Dr. Casariego and Dr. Patino concerning the hallucinations, I find the lack of detail about the voices an insufficient basis to impeach Mr. Martinez's credibility. Likewise, I specifically find no evidence of any pre-accident psychiatric problems. On the contrary, both Mr. Martinez and Ms. Martinez, while striving to obtain medical help for Mr. Martinez, have both consistently denied to the treating psychiatrists that any mental problems existed prior to the June 1996 accident. Neither Dr. Casariego nor Dr. Patino raised any suggestion that Mr. Martinez was hiding a past psychiatric history. Also, Mr. Martinez's steady and successful work history with Bradford Marine prior to the accident support the assertions by Ms. Martinez and Mr. Martinez that he was a normally functioning adult before his fall. Absent both a sound basis to doubt Mr. Martinez's credibility and any evidence of prior psychiatric problems, this particular explanation posited by Dr. Diaz is specious.

Dr. Diaz implicitly suggests another possible explanation by noting: a) his difficulty in reconciling Mr. Martinez's stated symptoms with Mr. Martinez's ability to endure international travel to Nicaragua; and, b) his refusal to concede that Mr. Martinez's psychiatric symptoms are not voluntary. In other words, Dr. Diaz has reservations about the veracity of Mr. Martinez's symptomatic presentation.

Concerning the international trips, Mr. Martinez has flown a couple of times to visit family in Nicaragua. The trips were carefully orchestrated to ensure family members were present to help Mr. Martinez at both airports. However, as even Dr. Diaz acknowledged, Mr. Martinez did not always successfully endure such trips. Although as Dr. Patino observed, Mr. Martinez can be stable for a period of time with medication, he was hospitalized in Nicaragua on one of the trips for a psychotic episode. Those Nicaraguan hospital treatment notes from September 1997 indicate Mr. Martinez was treated for convulsions and confusion (CX 3). In light of Mr. Martinez's medical experience in Nicaragua, his trips to that country hardly seem to caste doubt on his symptoms.

In regards to his implied opinion about voluntariness of Mr. Martinez's symptoms, Dr. Diaz has presented no psychological test results to validate his concern. Instead, Dr. Diaz seems to base his implicit explanation of fabrication on his inability to believe the June 1996 fall could have caused the psychosis. In contrast, the evidence in the record establishes at least two hospitalizations since 1997 for severe psychiatric disorder. During these hospital stays, he was evaluated by Dr. Casariego who reported severe psychiatric symptoms. Dr. Dergan also administered several psychiatric tests which revealed both cognitive and emotional disorders. In addition, Dr. Patino has treated Mr. Martinez for on-going psychosis. Based on the medical record before me, I consider Dr. Diaz's reservation about the involuntariness of Mr. Martinez's symptoms an insufficient rebuttal to the causation presumption. I see no evidentiary reason to conclude that Mr. Martinez is really voluntarily presenting his psychotic symptoms and has essentially fooled Dr. Casariego, Dr. Dergan and Dr. Patino.

Without directly referencing Mr. Martinez, Dr. Diaz also listed drug abuse, organic disease, such as a tumor, personality disorder, and major depression as possible, non-accident, etiologies for psychosis. Concerning drug abuse, other than Dr. Diaz's suggestion, the record is notably void of any evidence that Mr. Martinez is abusing drugs. In fact, upon his first admission to the hospital in February 1997, Mr. Martinez's drug screens were negative for the presence of illegal drugs. Likewise, the normal MRI and CT scan, while complicating the diagnosis in this case, clearly eliminate any brain disease or tumor as a cause for Mr. Martinez's mental deficiencies. Personality disorder is not a viable alternative since none of the psychiatrists, including Dr. Diaz, have diagnosed Mr. Martinez with a personality disorder. Major depression as a cause of psychosis is an interesting suggestion by Dr. Diaz because both Dr. Casariego and Dr. Patino have found Mr. Martinez to be suffering from major depression. And, Dr. Patino ties that depression to the consequences of the accident. So, rather than stand as a contrary cause of Mr. Martinez's mental disorder, his major depression may help establish a link between the accident and his psychosis.

A third shortfall in Dr. Diaz's assessment that adversely affects the probative value of his opinion is his reliance on an incorrect fact. As he attempted to explain why he found it difficult to link Mr. Martinez's mental problems to his fall, Dr. Diaz, relying on Mr. Martinez's March 1998 recollection that he did not lose consciousness after the accident, observed that Mr. Martinez had a head concussion with no loss of consciousness. Implicit in that statement is that the absence of any consciousness loss diminishes the severity of the concussion. However, despite Mr. Martinez's statement to Dr. Diaz, I find the preponderance of the evidence demonstrated that Mr. Martinez did slip into unconsciousness at least once on the day of the accident. Five days after the accident, Dr. Gran examined Mr. Martinez and recorded that he lost consciousness on the day of the accident. And, in his initial impression, Dr. Gran observed Mr. Martinez had "head trauma with loss of consciousness." About six months later, Dr. Corin recorded the same information; Mr. Martinez lost consciousness at least once on the day of the accident. And, both Dr. Patino and Dr. Casariego in their discussions of the accident observed that Mr. Martinez passed out. While Dr. Diaz may not be at fault for his incorrect finding because he relied on Mr. Martinez's March 1998 recollection, Dr. Diaz also asserted that he reviewed the medical reports concerning Mr. Martinez. As

noted above, these medical reports, in particular Dr. Gran's near contemporaneous evaluation, were replete with references to the loss of consciousness. At best, Dr. Diaz just simply didn't see those references and consequently failed to reconcile Mr. Martinez's presentation to him concerning no loss of consciousness and the medical record annotations showing he did pass out. On the other hand, Dr. Diaz's failure to discuss the inconsistency may be an adverse reflection on the thoroughness of his record review. In any event, a crucial factual underpinning for his assessment concerning causation is incorrect and inconsistent with my finding on the matter. As a result, since Dr. Diaz relied on that incorrect fact as partial reasoning for his conclusion, the probative value of his opinion is diminished.

In summary, in light of Dr. Diaz narrowed focus, his unfounded alternative explanations for Mr. Martinez's mental condition, and his reliance on the incorrect fact that Mr. Martinez did not lose consciousness as a result of his fall, I find the probative value of his medical opinion diminished to the point that it is insufficient to rebut the statutory causation presumption. Having failed to produce substantial contrary evidence, the Employer has failed to rebut the invoked causation presumption. Since the Section 20 (a) presumption remains in place, Mr. Martinez has established that his abnormal psychotic condition was caused by the head injury he suffered on June 9, 1996 in the course of, and during, his employment with Bradford Marine.

Additional Causation Discussion and Findings

If the Bradford Marine had presented substantial contrary evidence sufficient to rebut the Section 20 (a) presumption, then the presumption would no longer exist and the issue of causation is determined on the whole record. *Holmes v. Universal Maritime Services Corp.*, 29 BRBS 18 (1995). In that event, Mr. Martinez would bear the ultimate burden of proof to establish the connection between his injury and employment. See *Director, OWCP v. Greenwich Collieries*, 512 U.S. 267 (1994). Usually resolution of causation in this situation requires the evaluation of conflicting medical evidence. In that regard, an administrative law judge may place greater probative weight on the opinions of the employee's treating physician as opposed to the opinion of an examining or consulting doctor. *Pietrunti v. Director, OWCP* 11 F.3d 1035 (2d Cir. 1997).

Even if I had found Dr. Diaz's opinion did rebut the causation presumption, Mr. Martinez would still prevail on the causation issue and satisfy his ultimate burden of proof because upon considering the relative probative weight of the expert opinions in this case on causation, I consider the evaluations of Dr. Casariego, Dr. Dergan, and in particular, Dr. Patino better documented, reasoned and more probative than Dr. Diaz's evaluation.

Dr. Casariego provided a well documented and reasoned medial opinion linking Mr. Martinez's fall to his psychological infirmities. Unlike Dr. Diaz's one time evaluation of Mr. Martinez, Dr. Casariego had intensive interaction with Mr. Martinez during his two, 10 day hospitalizations. Based on his evaluations and treatment of Mr. Martinez at the hospital, his loss of consciousness shortly after the

accident, and significantly, Dr. Dergan's neuropsychological evaluation, Dr. Casariego remained convinced that Mr. Martinez's cognitive deficit was related to a concussion. While considering the absence of any abnormalities in the brain imaging tests, Dr. Casariego believed those tests did not preclude a diagnosis linking Mr. Martinez's ill mental health to the June 1996 accident. He acknowledged that in his practice the presentation of psychosis from brain injury was rare. But, pointing out the significant features of the neuropsychological test, and opining that psychotic symptoms would develop within a year of a brain injury, Dr. Casariego remained convinced that Mr. Martinez suffered mental harm from his fall.

Dr. Dergan also provided a well reasoned expert opinion that related the results of his neurological tests of Mr. Martinez to a brain concussion. In his practice, Dr. Dergan found a substantial number of patients with post concussion syndrome and normal brain scans. As a result, the normal brain imaging tests were not sufficient evidence to alter his opinion. Instead, Dr. Dergan found sufficient cognitive and emotional deficits to diagnose post-concussion brain syndrome.

Finally, Dr. Patino provided the best documented and reasoned medical opinion that is most consistent with all the medical evidence in the record. As Mr. Martinez's treating physician, he had intensive and extensive contact with Mr. Martinez. And, contrary to Dr. Diaz's supposition, I find no evidence that Dr. Patino's long term treatment of Mr. Martinez has rendered him less objective. In addition to his treatment of Mr. Martinez, Dr. Patino reviewed and considered all the medical tests in this case, including the non-supportive imaging evaluations, the supportive neuropsychological testings, and the hospitalization records. This extensive exposure to all the parameters of Mr. Martinez's situation gave Dr. Patino a very firm foundation for his conclusion that Mr. Martinez's mental condition is linked to his fall.

In terms of exceptional reasoning, Dr. Patino integrated all the medical evidence. He clearly recognized and considered the contrasting brain imaging reports, medical evaluations, and psychological test results. Then, he provided a comprehensive explanation for his diagnosis, including his observation that the psychological test rather than the imaging data, was the better diagnostic tool for determining causation.

Dr. Patino's assessment is also consistent with the preponderance of the medical evidence that shows Mr. Martinez suffered a concussion injury in his fall. Although the brain MRI and CT scan did not find any organic damage, Mr. Martinez suffered a severe enough fall on June 9, 1996 to cause him to lose consciousness and experience disorienting dizziness. Within five days of the fall, a board certified neurologist, Dr. Gran, diagnosed post-concussion brain syndrome. Eventually, Mr. Martinez's performance at work deteriorated, and the dizziness increased. About seven months after the fall, another board certified neurologist, Dr. Corin, also diagnosed post-concussion brain syndrome and recommended psychiatric care. Notably, while neither Dr. Gran nor Dr. Corin rendered an opinion as to causation, the only concussion Mr. Martinez suffered before their evaluations occurred on June 9, 1996. About eight months after the accident, Mr. Martinez required psychiatric hospitalization and the attending physician, Dr. Casariego, relying in part on Dr. Dergan's neuropsychological evaluation showing concussion brain

damage, diagnosed a concussion syndrome.

Ultimately, after determining the relevant probative value of the conflicting opinion in this case, the highly probative expert opinions of Dr. Patino, Dr. Casariego, and Dr. Dergan, overwhelm Dr. Diaz's diminished opinion. Even in the absence of the Section 20 (a) causation presumption, Mr. Martinez is able to prove through the preponderance of the more probative expert opinion that his fall from a scaffold on June 9, 1996 caused him psychological and psychiatric harm.

Extent and Nature of Mr. Martinez's Disability

Under the Act, a longshoreman's or harbor worker's inability to work due to a work-related injury is addressed in terms of the extent of the disability (total or partial) and the nature of the disability (permanent or temporary). Since Mr. Martinez is seeking compensation for a work-related injury, he has the burden of proving, through the preponderance of the evidence, both the extent and nature of any disability. *Trask v. Lockheed Shipbuilding Construction Co.*,17BRBS 56, 59 (1985).

Issue No. 2 - Extent of Disability

The question of the extent of a disability, total or partial, is an economic as well as a medical concept. *Rinaldi v. General Dynamics Corp.*, 25 BRBS 128,131 (1991). The Act defines disability as an incapacity due to an injury to earn wages which the employee was receiving at the time of injury in the same or other employment. *McBride v. Eastman Kodak Co.*, 844 F.2d 797 (DC Cir. 1988). Total disability occurs if a claimant is not able to adequately return to his or her pre-injury, regular, full-time employment. *See Del Vacchio v. Sun Shipbuilding & Dry Dock Co.*, 16 BRBS 190, 194 (1984). A disability compensation award requires a causal connection between the claimant's injury and his or her inability to obtain work. The claimant must show an economic loss coupled with a physical and/or psychological impairment. *Sproull v. Stevedoring Servs. of America*, 25 BRBS 100, 110 (1991). Under this standard, a claimant may be found to have either suffered no loss, a partial loss, or a total loss of wage-earning capacity.

Determining the extent of a disability, and consequently whether an award of disability benefits is appropriate, involves a three step process. *SEACO and Signal Mutual Indemnity Assoc., Limited v. Bess*, 120 F. 3d 262 (4th Circuit 1997) (unpublished); see also, *Newport News Shipbuilding & Dry Dock Company v. Tann*, 841 F.2d 540, 542 (4th Circuit 1988). As a first step, to establish a *prima facie* case of total disability, whether temporary or permanent in nature, a claimant has the initial burden of proof to show that he cannot return to his regular or usual employment due to work-related injuries. This evaluation of loss of wage earning capacity focuses both on the work that an injured employee is still able to perform and the availability of that type of work which he can do. *McBride*, 844 F. 2d at 798. A claimant's credible testimony of considerable pain while performing work may be a sufficient basis for a disability compensation even though other evidence indicates the claimant has the capacity to do certain types of work. *Mijangos v. Avondale Shipping, Inc.*, 948 F. 2d 194 (8th Cir. 1999) and *Anderson v. Todd Shipyards Corp.*, 22 BRBS 20 (1989). In addition, a physician opinion that the employee's return to his

usual or similar work would aggravate his condition, may also be sufficient to support a finding of disability. *Case v. Washington Metro. Area Transt. Auth.,* 21 BRBS 248 (1988).

In the second step, if the claimant is able to demonstrate he or she is unable to return to his or her former job, then the employer has the burden of production to show that suitable alternate employment is available. *Nguyen v. Ebbtide Fabricators*, 19 BRBS 142 (1986). The availability of suitable alternative employment involves defining the type of jobs the injured worker is reasonably capable of performing, considering his or her age, education, work experience and physical restrictions, and determining whether such jobs are reasonably available in the local community. *Newport News Shipbuilding and Dry Dock Co. v. Director,* OWCP, 592 F.2d 762, 765 (4th Cir. 1978) and New *Orleans (Gulfwide) Stevedores v. Turner*, 661 F.2d 1031, 1038 (5th Cir. 1981). The showing of available suitable alternative employment may not be applied retroactively to the date of maximum medical improvement. An injured worker's total disability becomes partial on the earliest date that the employer shows suitable alternative employment. *Rinaldi v. General Dynamics Corp.*, 25 BRBS 128, 131 (1991).

And, at the third step, if the employer demonstrates that suitable alternate employment was available, then to meet his or her burden of proof, the claimant must show he or she has tried to obtain such alternate employment but has been unable to do so. *Williams v. Halter Marine Service*, 19 BRBS 248 (1987). Otherwise, the extent of the employee's disability is partial, not total. *Director, Office of Worker's Compensation Programs v. Berkstresser*, 921 F. 2d 306, 312 (D.C. Cir. 1991).

At the end of this three step process, if a claimant does not meet the burden of proof for total disability, then he or she is considered employable and at the most his or her disability is partial, not total. *See Southern v. Farmers Export Company*, 17 BRBS 64 (1985). In summary, to show total disability under the Act, Mr. Martinez must establish that his psychological and psychotic impairment adversely affects his economic well-being by preventing him from earning his pre-injury wages.

Prima Facie Case of Total Disability

Prior to his injury, Mr. Martinez was a painter helper at Bradford Marine. This was a full time job that required Mr. Martinez to work at heights as part of a painter crew, assisting co-workers and painters. To work in that capacity, I believe Mr. Martinez must be at least a minimally normal adult from a psychological perspective. In particular, the work would require Mr. Martinez to concentrate, remained focused on his job tasks during the entire eight hour work day and rationally interact with his co-workers.

For the following reasons, and based principally on the more probative opinions of Dr. Patino, Dr. Casariego, and Dr. Dergan, I believe Mr. Martinez presently lacks the requisite psychiatric health to return to work at Bradford Marine. Shortly after his fall and head injury, Mr. Martinez did attempt to return to work in light duty, but his inability to produce steady work, concentrate, and get along with co-workers

eventually caused his supervisor to have concerns about his employment. Eventually, Mr. Martinez left work and sought psychiatric help from Dr. Patino.

Over the course of his treatment of Mr. Martinez, Dr. Patino concluded he is severely impaired due to his psychiatric condition. According to Dr. Patino, Mr. Martinez struggles with cyclical depression and feelings of hopelessness and experiences periods involving withdrawal and failure to care for himself. Medication helps Mr. Martinez but according to Dr. Patino his psychotic state is "very brittle." If Mr. Martinez attempted work, he would probably experience a relapse. Based on his chronic psychosis, Dr. Martinez opined Mr. Martinez is unemployable.

Dr. Casariego's treatment of Mr. Martinez's mental collapse during both hospitalizations further illustrates both the depth of Mr. Martinez's psychosis and its cyclical nature. During these occasions, in addition to retreating from day to day life, Mr. Martinez experiences visual and auditory hallucinations. Dr. Casariego also found Mr. Martinez handicapped due to his psychosis.

Finally, Dr. Dergan's neuropsychological tests indicating both cognitive and emotional deficits also support a finding that Mr. Martinez lacks the psychotic health to return to work at Bradford Marine.

I note that Dr. Gran, Dr. Corin, and Dr. Diaz all believe Mr. Martinez is capable of returning to work. The two neurologists' opinions have little relevant probative weight since they based their return to work conclusion solely on absence of any neurologic impairment. Even after Dr. Corin stated Mr. Martinez could return to work, from a neurological perspective, he suggested Mr. Martinez seek psychiatric help. As discussed before, I give Dr. Diaz's assessment of Mr. Martinez's psychiatric condition less, relative probative weight in comparison to the opinions of Dr. Patino, Dr. Casariego, and Dr. Dergan. I also note Dr. Diaz's opinion that Mr. Martinez is capable of returning to work without any restriction seems to contradict one of his earlier findings. According to Dr. Diaz, Mr. Martinez's GAF rating is 65, which seems to be well below the 85 to 90 score Dr. Diaz would expect a normally functioning adult to achieve. In fact a GAF of 65 is closer to the 50 point GAF rating that Dr. Patino considers the hospitalization threshold.

In summary, considering Mr. Martinez's failed attempt to return to work at Bradford Marine, his periodic psychiatric hospitalizations, his abnormal neuropsychological test results, his chronic psychosis and long-term therapy with Dr. Patino, and Dr. Patino's most probative medical opinion, I find Mr. Martinez is unable to return to work at Bradford Marine due to his work-related psychotic injury. Accordingly, Mr. Martinez has established a *prima facie* case of total disability.

Suitable Alternative Employment

Since Mr. Martinez has established a *prima facie* case of total disability, the Employer in the second step of the adjudication process has an opportunity to rebut the *prima facie* case by showing suitable alternative employment.

At my hearing, the Employer made a small, and completely ineffective, gesture to show Mr. Martinez remained employable. Based on his labor market expertise, Mr. Adato was able to present an abundant array of jobs for Mr. Martinez. Unfortunately, as Mr. Adato admitted, he was instructed to prepare his survey based solely on the work restrictions presented by Dr. Gran, Dr. Corin, and Dr. Diaz. As previously mentioned, for various reasons, those physicians believed Mr. Martinez was capable of returning work with only a working height limitation. Since their opinions that Mr. Martinez is essentially fine are contrary to my finding that Mr. Martinez has a severe psychotic impairment, a labor market survey based solely on their restrictions has no probative value in this case.

Since the Employer has failed to present a labor market survey that takes into account Mr. Martinez's psychiatric condition, the Employer has failed to rebut Mr. Martinez's *prima facie* showing of total disability. As a result, I conclude the extent of Mr. Martinez's psychiatric impairment is total. That is, due to his mental injury, Mr. Martinez has suffered a complete loss of wage earning capacity.

Issue No. 3 - Nature of Disability

The nature of a disability, permanent or temporary, is typically defined by the date of maximum medical improvement ("MMI"). *Trask,* 17 BRBS at 60. A claimant reaches MMI when the injuries from the work-related accident have stabilized and no further improvement is anticipated. *Thompson v. Quinton Enterprise, Ltd.*, 14 BRBS 395, 401 (1981) and *Dixon v. Cooper Stevedoring Co.*, 18 BRBS 25, 32 (1986). Any disability suffered by a claimant prior to MMI is considered temporary in nature. *Berkstresser v. Washington Metropolitan Area Transit Authority*, 16 BRBS 231 (1984). If a claimant has any residual disability after reaching MMI, then the nature of the disability is permanent. *Sinclair v. United Food & Commercial Workers*, 13 BRBS 148 (1979).

Several physicians addressed the issue of MMI. Both Dr. Gran and Dr. Corin believed Mr. Martinez had recovered from any neurological injuries in August 1996 and February 1997 respectively. However, their assessments are not particularly relevant because they didn't address the nature of Mr. Martinez's psychiatric impairment. Dr. Dergan also did not provide much information on the subject because he wanted to conduct another test for comparison before rendering an opinion on the permanency of Mr. Martinez's mental condition.

The three psychiatrists generally agree that Mr. Martinez has reached MMI. In his evaluation but without explanation, Dr. Diaz found Mr. Martinez had reached MMI on March 30, 1997. Dr. Patino also stated Mr. Martinez had reached MMI in this case, but didn't set a specific date. And, Dr. Casariego, while not actually using the term "MMI," opined that Mr. Martinez's condition was chronic and severe. His prognosis was "guarded."

Considering Dr. Diaz's belief that Mr. Martinez was employable and had very little residual mental impairment (3%), his finding of MMI does not support a finding that Mr. Martinez has a chronic disabling

psychiatric impairment. On the other hand, both Dr. Patino and Dr. Casariego clearly concur in their opinions that Mr. Martinez's disabling psychosis has become chronic. Despite his long term therapy with Dr. Patino and two psychiatric hospitalizations with Dr. Casariego, Mr. Martinez continues to struggle with an severely impaired psychotic condition. Based on Mr. Martinez's psychiatric medical history indicating little, or no improvement, over the course of his psychiatric treatment and the more probative opinions of Dr. Patino and Dr. Casariego, I conclude Mr. Martinez's work-related mental injury has become a permanent ailment.

Setting the actual date of the permanency or MMI is problematic. In light of Dr. Diaz's suspicions about Mr. Martinez's psychosis, and absent any explanation, I believe his March 30, 1997 date for MMI is related to Dr. Corin's assessment in February 1997 that any neurological problems had been resolved. However, as I stated before, the healing of Mr. Martinez's wrist and neurological problems does not address the prognosis for his mental injury. As a result, I do not accept Dr. Diaz's date for MMI.

Turning to the other two psychiatrists, neither Dr. Patino nor Dr. Casariego set an actual date for MMI. I could have chosen the date of Mr. Martinez's last hospitalization in July 1998 as the date of MMI since Dr. Casariego believed the re-hospitalization was an indication that Mr. Martinez's condition was chronic. But, I believe reliance on the most probative opinion of Dr. Patino is more appropriate. In his March 1999 deposition, Dr. Patino specifically opined that Mr. Martinez's condition had become stationary and he would require treatment for "years." Consequently, Dr. Patino believed Mr. Martinez had reached MMI. Dr. Patino also stated that his last visit with Mr. Martinez occurred on January 28, 1999. Since that is the last examination date prior to Dr. Patino's definitive finding of MMI, I conclude Mr. Martinez had reached maximum medical improvement by January 28, 1999. On that date, the nature of Mr. Martinez's impairment became permanent.

Issue No. 4 - Attendant Care

Under Section 7 (a) of the Act, an employer shall furnish all reasonable and necessary medical care and other attendant care or treatment, hospitalization, and medication for a work-related injury. *Parnell v. Capitol Hill Masonry*,11 BRBS 532, 539 (1979). A claimant may establish a *prima facie* case of compensable medical treatment where a qualified physician indicates such treatment is necessary for a work-related injury. *Turner v. Chesapeake & Potomac Tel. Co.*, 16 BRBS 255, 2 157-258 (1984). Such expenses may also include reimbursement for attendant care provided by a family member. *See Timmons v. Jacksonville Shipyards*, 2 BRBS 125 (1975); *Edwards v. Zapata Offshore* Company, 5 BRBS 429 (1977); *Gilliam v. Western Union Telegraph Company*, 8 BRBS 278 (1978); and *Sanders v. Marine Terminals*, 31 BRBS 19 (1997).

In response to Mr. Martinez's claim for attendant care expenses, the Employer first presents Dr. Diaz's opinion that Mr. Martinez does not need attendant care. Once again, based on relative probative value, I am more persuaded by Dr. Patino's and Dr. Casariego's judgments on this issue. Both these treating psychiatrists strongly recommend continued attendant care for Mr. Martinez.

Second, the Employer highlights some inconsistencies in witnesses' statements and testimony as a basis for questioning the factual need for such services. While some of the witnesses' recollections may have been too generalized, I believe Dr. Patino had a sufficient background, particularly in light of Mr. Martinez's two hospitalizations precipitated by his willful neglect of taking his medication, to conclude Mr. Martinez does need some supervision. Dr. Casariego essentially supports that position. Pointing out that Mr. Martinez's attempts to live alone led to problems concerning his medication and depression, Dr. Casariego concluded Mr. Martinez needed further active support beyond hospitalization and therapy. The more probative, and concurring, opinions of Dr. Patino and Dr. Casariego establish a medical necessity for attendant care to assist Mr. Martinez with the consequences of his psychosis.

While I find the preponderance of the record demonstrates the medical need for attendant care, the actual duration and extent of such care, and its reasonable costs, are less certain. Dr. Casariego didn't quantify the degree of such attendant care. Similarly, Dr. Patino was less than clear on the matter. In an indorsement to a letter from the Employer's counsel, Dr. Patino seemed to indicate that Mr. Martinez needed help twice a day to take his medication for a total of 10 minutes and he needed someone to check on him during his waking hours two to three times day, for a total of 45 minutes (EX 6). Employer's counsel interpreted this indorsement to mean Mr. Martinez needed supervision for only one hour a day. However, in his deposition, Dr. Patino expressed his opinion that Mr. Martinez may need more care.

I interpret Dr. Patino's indorsement and his testimony to mean that Mr. Martinez needs periodic attention during the day to monitor his consumption of his medication and activities. While the total contact time may amount to no more than one hour, the attendant still must make some accommodations to be available throughout the day to accomplish the periodic checks. At the same time, the attendant does not necessarily have to be present at the start and end of Mr. Martinez's waking hours and full compensation for the time the attendant is not with Mr. Martinez seems inappropriate. Accordingly, I find Employer should be responsible for the expense associated with four (4) hours of attendant care a day. If a family member provides such care, and in the absence of any evidence to the contrary, the appropriate rate of compensation shall be the Federal hourly minimum wage.[10] If a health care provider renders the attendant care, reimbursement will be computed in accordance with 20 C.F.R. §702.413.

Concerning the prospective reimbursement of attendant care expenses, the Claimant or an appropriate family member shall provide the Employer or its insurer either the medical care provider's bill for four hours of daily care, or a monthly accounting of the actual days Mr. Martinez received attendant care from family members.

On the issue of reimbursement for past family-provided attendant care, Counsel for the Claimant suggests reimbursement start with Mr. Martinez's March 1997 release from his first hospitalization. I

[10]Counsel for the Claimant suggested the Federal minimum wage as an appropriate compensation rate.

disagree. While Dr. Casariego did first suggest some sort of attendant care for Mr. Martinez upon his release from the hospital in March 1997, the evidentiary record is insufficient to determine whether family members, in particular, Mr. Martinez's sister, have provided constant, daily attendant care since that time. Pointedly, Mr. Martinez's subsequent hospitalization in June 1998 seems to suggest that he did not receive sufficient attendant care. I don't doubt Mr. Martinez's sister has endured a great deal as the principal care provider for her brother. But, the Claimant bears the burden of proof on this issue and while reimbursement for his sister's time may be warranted, I am unable to fairly determine the exact amount of reimbursement for her past attendant care. Accordingly, Mr. Martinez's claim for reimbursement of expenses associated with past attendant care must be denied.

ATTORNEY FEE

Section 28 of the Act, 33. U.S.C. § 928, permits the recoupment of a claimant's attorney's fees and costs in the event of a "successful prosecution." Since I have determined issues in favor of Mr. Martinez, Mr. Pemsler is entitled to submit a petition to recoup his fees and costs associated with his professional work before the Office of Administrative Law Judges. Mr. Pemsler has thirty days from receipt of this decision and order to file an application for attorney fees and costs as specified in 20 C.F.R. § 702.132 (a). Mr. Cristal or Mr. Sponsler then have ten days from receipt of such fee application to file an objection to the request. In light of the denial of a portion of Mr. Martinez's claim relating to attendant care reimbursement, the parties should address whether any reduction of an attorney fee award is appropriate. *See Hensley v. Eckerhart*, 461 U.S. 424 (1983) and *George Hyman Co. v. Brooks*, 963 F.2d 1532 (D.C. Cir. 1992).

ORDER

Based on my findings of fact, conclusions of law, and the entire record, I issue the following order. The specific dollar computations of the compensation award shall be administratively performed by the District Director.

1. The Employer **SHALL PAY** Mr. MANUEL J. MARTINEZ compensation for **TEMPORARY TOTAL DISABILITY** due to a psychological and psychotic injury caused by a June 9, 1996 accident, based on Mr. Martinez's pre-injury average weekly wage ($340) through January 27, 1999, such compensation to be computed in accordance with Section 8 (b) and offset for days Mr. Martinez returned to work in light duty.

2. The Employer **SHALL PAY** Mr. MANUEL J. MARTINEZ compensation for **PERMANENT TOTAL DISABILITY** due to a psychological and psychotic injury caused by a June 9, 1996 accident, based on Mr. Martinez's pre-injury average weekly wage ($340) from January 28, 1999, such compensation to be computed in accordance with Section 8 (a).

3. As of the date this Decision and Order is issued, the Employer **SHALL PAY REIMBURSEMENT** for four (4) hours of daily attendant care provided to Mr. MANUEL J. MARTINEZ by either a family member, such compensation to be based on the Federal hourly minimum wage and a monthly accounting provided to the Employer or its Insurer of the days care has been provided, or a medical care provider, such compensation computed in accordance with 20 C.F.R. §702.413.

4. The claim of Mr. MANUEL J. MARTINEZ for reimbursement of past attendant care provided by family members is **DENIED**.

5. The Employer **SHALL RECEIVE CREDIT** for all amounts of compensation previously paid to the Mr. MANUEL J. MARTINEZ as a result of his psychological and psychotic injury from the June 9, 1996 accident.

6. Following the credit offset, the Employer **SHALL PAY INTEREST** on each remaining unpaid installment of compensation from the date the compensation became due at the rates specified in 28 U.S.C. § 1961.

SO ORDERED:

RICHARD T. STANSELL-GAMM
Administrative Law Judge

Washington, D.C.